CHARIS
Counseling Center

Baldwin Park (Main Office)- 1543 Lake Baldwin Ln, Suite B
Orlando, FL 32814
Southwest Orlando - 7345 W. Sand Lake Road Suite 303
Orlando, FL 32819
Titusville - 2323 Washington Ave, Suite 213
Titusville, FL 32780
Phone: 407.894.5202
www.chariscounselingcenter.com

Statement of Counseling Policies and Procedures

COUNSELING SESSIONS:
Counseling sessions last fifty (50) minutes, a clinical hour, unless previously arranged with your therapist. Sessions typically begin on the hour and end at fifty minutes after the hour; therefore it will be to your advantage to arrive on time so that you can benefit from a full length. Please remember the importance of keeping your appointment.

CANCELLATIONS AND RESCHEDULING:

- If for some reason you must cancel your appointment, notify our office at (407) 894-5202 as soon as you know you cannot keep the appointment. You may leave a voicemail if it is after hours. Please do not email your counselor or the receptionist with your cancellation.
- **24-hour <u>business day notice</u> is required in order to avoid payment for the scheduled session. Business days constitute Monday-Friday. Therefore, if an appointment is scheduled for Monday at 9A then notice in regard to cancellation MUST be received by 9A on the Friday prior to Monday appointment.**
- Repeated cancellations or frequent "no-shows" will mean that further appointments may not be scheduled.

FEES FOR COUNSELING:
The fee for your counseling sessions is $_____ per clinical hour. Counseling fees are due at the end of each session. You may pay by MasterCard, American Express, Visa, Discover, cash or check (please make checks payable to Charis Counseling Center) either before or immediately following your session.
*Please be aware that phone communications are considered appointments and will be charged per quarter hour. Further, email correspondence may be charged at the discretion of your counselor.

INSURANCE AND RECEIPTS:
We do not accept third-party payments for service and the counseling fees are due immediately following your session. We will be happy to provide you with a receipt for your services along with the proper coding information for you to submit to your insurance provider. If we can offer any advice on submittals, please don't hesitate to ask.

EMERGENCY SITUATIONS:
If at any time you become extremely emotionally distressed or are in danger of hurting yourself or someone else, please call 911 for assistance. We do not provide on-call or emergency services at this time.

CONTACTING US:
You may email your counselor at: _____@chariscounselingcenter.com. You may also contact our office using the contact information provided at the top of this form.

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Notice of Privacy Practices

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW THIS DOCUMENT CAREFULLY.

The Health Insurance Portability & Accountability Act of 1996 (HIPAA) requires all health care records and other individually identifiable health information (protected health information) used or disclosed to us in any form, whether electronically , on paper, or orally, be kept confidential. This federal law gives you, the patient, significant new rights to understand and control how our health information is used. HIPAA provides penalties for covered entities that misuse personal health information. As required by HIPAA, we have prepared this explanation of how we are required to maintain the privacy of your health information and how we may use and disclose your health information.

Without specific written authorization, we are permitted to use and disclose your health care records for the purposes of treatment, payment, and health care operations.

-*Treatment* means providing, coordinating, or managing health care and related services by one or more health care providers. Examples of treatment would include psychotherapy, medication management, etc.

-*Payment* means such activities as obtaining reimbursement for services, confirming coverage, billing or collection activities, and utilization review. An example of this would be billing your insurance company for your services.

-Health Care Operations include the business aspects of running our practice, such as conducting quality assessment and improvement activities, auditing functions, cost-management analysis, and customer service. An example would include a periodic assessment of our documentation protocols, etc.

In addition, your confidential information may be used to remind you of an appointment (by phone or mail) or provide you with information about treatment options or other health-related services. We will use and disclose your PROTECTED HEALTH INFORMATION when we are required to do so by federal, state or local law. We may disclose your PROTECTED HEALTH INFORMATION to public health authorities that are authorized by law to collect information to a health oversight agency for activities authorized by law included but not limited to: response to a court or administrative order, if you are involved in a lawsuit or similar proceeding; response to a discovery request, subpoena, or other lawful process by another party involved in the dispute, but only if we have made an effort to inform you of the request or to obtain an order protecting the information the party has requested. We may release your PROTECTED HEALTH INFORMATION to a medical examiner or coroner to identify a deceased individual or to identify the cause of death. We may use and disclose your PROTECTED HEALTH INFORMATION when necessary to reduce or prevent a serious threat to your health and safety or the health and safety of another individual or the publix. Under these circumstances, we will only make disclosures to a person or organization able to help prevent the threat.

Any other uses and disclosures will be made only with your written authorization. You may revoke such authorization in writing and we are required to honor and abide by that written request, except to the extent that we have already taken actions relying on your authorization.

You have certain rights in regards to your PROTECTED HEALTH INFORMATION, which you can exercise by presenting a written request to our Privacy Officer at the practice address listed below:
-The right to request restrictions on certain uses and disclosures of PROTECTED HEALTH INFORMATION, including those related to disclosures to family members, other relatives, close personal friends, or any other person identified by you. We are, however, not required to agree to a requested restriction. If we do agree to a restriction, we must abide by it unless you agree in writing to remove it.

-The right to request to receive confidential communications of PROTECTED HEALTH INFORMATION from us by alternative means or at alternative locations.

-The right to request an amendment to your PROTECTED HEALTH INFORMATION.

-The right to receive an accounting of disclosures of PROTECTED HEALTH INFORMATION outside of treatment, payment and health care operations.

-The right to obtain a paper copy of this notice for us upon request.
We are required by law to maintain the privacy of your PROTECTED HEALTH INFORMATION and to provide you with notice of our legal duties and privacy practices with respect to PROTECTED HEALTH INFORMATION.

We are required to abide by the terms of the Notice of Privacy Practices currently in effect. We reserve the right to change the terms of our Notice of Privacy Practices and to make the new notice provisions effective for all PROTECTED HEALTH INFORMATION that we maintain. Revisions to our Notice of Privacy Practices will be posted on the effective date and you may request a written copy of the Revised Notice from this office.

You have the right to file a formal, written complaint with us at the address below, or with the Department of Health & Human Services, Office of Civil Rights, in the event you feel your privacy rights have been violated. We will not retaliate against you for filing a complaint.

For more information about our Privacy Practices, please contact:

The Privacy Officer
Charis Counseling Center, LLC.
1543 Lake Baldwin Lane
Orlando, FL 32814
(407) 894-5202

For more information about HIPAA or to file a complaint:

The U.S. Department of Health & Human Services
Office of Civil Rights
200 Independence Ave, S.W.
Washington, D.C. 20201
877.696.6775 (toll-free)

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Acknowledgment of Receipt: Privacy Practice Notice

I, _____ have received a copy of Charis Counseling Center, LLC.
(Parent/Guardian Name) Notice of Privacy Practices.

Street Address:_____

City:_____ State:_____ Zip:_____

I, _____ have received a copy of Charis Counseling Center, LLC.
(Client-Child/Adolescent Name) Notice of Privacy Practices.

If Different from above:

Street Address:_____

City:_____ State:_____ Zip:_____

Client-- Child/Adolescent

Signature: _____ Date:_____

Parent/Guardian

Signature:_____ Date:_____

TERMS OF SERVICE

I understand that it is customary to pay for professional services when rendered. I accept full responsibility for payment of any balance incurred for services. I further understand that without 24-hour notice of cancellation, I will be charged the full fee for professional service.

Signed: _____ Date: _____

All accounts are requested to have a credit card on file to reserve appointments. This information will be kept confidential and will only be used to process payments at your request or to bill for late cancellations and missed appointments.

For Office Staff Only:

Signature:_____ Date Received:_____

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Informed Consent and Release of Liability

Client (Child/Adolescent) Name (please print):_____

Our goal is to minister to you with counseling from a Christian perspective. We desire to work with clients who have the capacity to resolve their own problems with our assistance. Some clients need only a few sessions to achieve these goals while others may require many more. As a client, you have the right to end our counseling relationship at any point.

1. I understand that my counselor is working under Florida laws, rules and statutes as a Licensed Mental Health Counselor or as a Registered Intern under the supervision of a licensed counselor.

2. I understand that my counseling records are kept confidential, except where disclosure is required by law or the ethics of the counseling profession (i.e. abuse of a child, elderly or disabled person; potential harm or threat to self or others; child custody cases that go before a court of law; and specific information subpoenaed by a court of law).

3. In consideration of the benefits to be derived from the counseling, the receipt wherof is hereby acknowledged, I hereby release, remise and forever discharge and covenant not to sue or hold legally liable Charis Counseling Center, LLC., its employees or officers from any and all claims, demands, actions, or causes of action of whatsoever kind and nature related to the counseling process.

4. The clinical records are the property of Charis Counseling Center, LLC and are deemed records of confidential sessions between therapists and clients. I waive any right I may otherwise have to seek to use the clinical records of the counseling center as evidence in any judicial proceedings. I understand that if anyone from this office is subpoenaed or court ordered to testify in court as an expert witness, court fees are separate from the counselor's regular counseling rates and I will need to contract the Charis Office for the court fees.

5. Counseling sessions last approximately fifty (50) minutes. Please remember the importance of keeping your appointment. If for some reason you must cancel your appointment, notify our office as soon as you know you cannot keep the appointment. **24-hour business day notice is required in order to avoid payment for the scheduled session. Business days constitute Monday-Friday. Therefore, if an appointment is scheduled for Monday at 9A then notice in regard to cancellation MUST be received by 9A on the Friday prior to Monday appointment.** Repeated cancellations or frequent "no-shows" will mean that further appointments may not be scheduled. Counseling fees are due at the end of each session by cash, check made payable to *Charis Counseling Center,* or credit card (American Express, MasterCard, Discover or VISA).

6. If at any time you become emotionally distressed or are in danger of hurting yourself or someone else, please call 911 for assistance. We do not provide an on-call service at this time.

My signature below indicates that I grant informed consent for Charis Counseling Center to provide psychological services and counseling to myself and/or minor members of my family.

_____ /_____ _____ /_____
Parent/Guardian Signature Date Client/Child-Adolescent Signature Date

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Credit Card Authorization Form

Client Name:_____

Client Address:_____

Our credit card processing is completed through Square. Your credit card will be stored securely through their software. You will receive an email from Square once your credit card has been linked to your profile. You may opt to receive receipts via email if you so wish.

Email:_____

I have read and acknowledge that I will receive emails from square. _____**Initial**
I wish to receive electronic email receipts. _____**Initial**

Please complete all fields. You may cancel this authorization at any time by contacting us. This authorization will remain in effect until cancelled.

Credit Card Information
Card Type: ☐ MasterCard ☐ VISA ☐ Discover ☐ AMEX
Cardholder Name (As shown on card): _____
Card Number: _____
Expiration Date (mm/yy): _____ CCV: _____
Cardholder ZIP Code (from credit card billing address): _____

I, _____, authorize Charis Counseling Center to charge my credit
(Cardholder)
card above for services provided to _____. I understand that my information will be
(Client Name)
saved for future transactions on this account.

_____ _____
Cardholder Signature Date

_____ _____
Client Signature (If different) Date

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Confidential Child/Adolescent History Form

PARENT/GUARDIAN COMPLETES THIS SECTION:

Therapist: _____

Date:_____ Referred by:_____

Child/Adolescent's Name:_____ Name Preferred:_____

Sex: ☐ Male ☐ Female Age: _____ Date of Birth: _____ If Applicable Phone:_____

Home Address: _____ City: _____ State:_____ Zip:_____

Mother's Name:_____ Name Preferred:_____

May we contact client's mother? ☐ Yes ☐ No

Mailing Address: _____

City: _____ State: _____ Zip Code: _____ May we send mail here: ☐ Yes ☐ No

Home Address (if different): _____

City: _____ State: _____ Zip Code: _____ May we send mail here: ☐ Yes ☐ No

Home Phone: (_____)_____ May we leave a message here: ☐ Yes ☐ No

Cell Phone: (_____)_____ May we leave a message here: ☐ Yes ☐ No

Work Phone: (_____)_____ May we leave a message here: ☐ Yes ☐ No

Email Address: _____ May we send a message here: ☐ Yes ☐ No

Father's Name:_____ Name Preferred:_____

May we contact client's father? ☐ Yes ☐ No

Mailing Address: _____

City: _____ State: _____ Zip Code: _____ May we send mail here: ☐ Yes ☐ No

Home Address (if different): _____

City: _____ State: _____ Zip Code: _____ May we send mail here: ☐ Yes ☐ No

Home Phone: (_____)_____ May we leave a message here: ☐ Yes ☐ No

Cell Phone: (_____)_____ May we leave a message here: ☐ Yes ☐ No

Work Phone: (_____)_____ May we leave a message here: ☐ Yes ☐ No

Email Address: _____ May we send a message here: ☐ Yes ☐ No

EMERGENCY CONTACT

Name: _____ Relationship: _____

Home Phone: _____ Mobile Phone: _____

PARENT/GUARDIAN COMPLETES THIS SECTION:

Primary Custodial Parent or Guardian:_____

Relationship to Child/Adolescent: _____ Phone: _____

With whom does the child/adolescent currently live? *(Check all that apply)*:

☐ Alone ☐ Parent(s) ☐ Sibling(s) ☐ Grandparents ☐ Friend ☐ Other:_____

PRESENTING ISSUES AND GOALS

What has led you to seek counseling for your child/adolescent at this time?_____

_____

_____

_____

What specific goals do you hope your child/adolescent will achieve during the counseling experience? _____

_____

_____

_____

Please check any of the following problem areas that pertain to your child / adolescent and family:

Stress	☐You ☐Family	Nervousness	☐You ☐Family	Anxiety	☐You ☐Family
Panic	☐You ☐Family	Unhappiness	☐You ☐Family	Depression	☐You ☐Family
Guilt	☐You ☐Family	Apathy	☐You ☐Family	Terminal Illness	☐You ☐Family
Recent Death	☐You ☐Family	Grief	☐You ☐Family	Hopelessness	☐You ☐Family
Inferiority Feelings	☐You ☐Family	Defective Feelings.	☐You ☐Family	Loneliness	☐You ☐Family
Shyness	☐You ☐Family	Fears	☐You ☐Family	Friends	☐You ☐Family
Marriage	☐You ☐Family	Communication	☐You ☐Family	Physical Abuse	☐You ☐Family
Emotional Abuse	☐You ☐Family	Verbal Abuse	☐You ☐Family	Sexual Abuse	☐You ☐Family
Temper	☐You ☐Family	Anger	☐You ☐Family	Aggressiveness	☐You ☐Family
Bad Dreams	☐You ☐Family	Concentration	☐You ☐Family	Racing Thoughts	☐You ☐Family
Unwanted Thoughts	☐You ☐Family	Memory	☐You ☐Family	Loss of Control	☐You ☐Family
Impulsive Behavior	☐You ☐Family	Self-Control	☐You ☐Family	Compulsivity	☐You ☐Family
Sexual Problems	☐You ☐Family	Pregnancy	☐You ☐Family	Abortion	☐You ☐Family
Legal Matters	☐You ☐Family	Trauma	☐You ☐Family	Eating Problems	☐You ☐Family
Drug Use	☐You ☐Family	Alcohol Use	☐You ☐Family	Trouble with Job	☐You ☐Family
Career Choices	☐You ☐Family	Ambition	☐You ☐Family	Making Decisions	☐You ☐Family
Children	☐You ☐Family	Being a Parent	☐You ☐Family	Finances	☐You ☐Family
Recent Loss	☐You ☐Family	Disaster	☐You ☐Family	Other	☐You ☐Family

CURRENT STATUS

Please check any of the following physiological symptoms that apply to your child/adolescent:

Headaches	☐Past ☐Present	Dizziness	☐Past ☐Present	Stomach Trouble	☐Past ☐Present
Visual Trouble	☐Past ☐Present	Sleep Trouble	☐Past ☐Present	Trouble Relaxing	☐Past ☐Present
Weakness	☐Past ☐Present	Tension	☐Past ☐Present	Rapid Heart Rate	☐Past ☐Present
Difficulty Breathing.	☐Past ☐Present	Intestinal Trouble	☐Past ☐Present	Hearing Noises	☐Past ☐Present
Change in Appetite.	☐Past ☐Present	Tiredness	☐Past ☐Present	Pain	☐Past ☐Present
Hearing Voices	☐Past ☐Present	Seeing Things	☐Past ☐Present	Other	☐Past ☐Present

How has their weight changed in the last 2-3 months? (If so, how?) _____

Education:

School:_____ Grade:_____

Is your child/adolescent in any special education/exceptional education programs? ☐Yes ☐No

If yes, what kind of program?_____

Does your child have an IEP? ☐ Yes ☐ No

If yes, please describe:_____

Has your child/adolescent ever had any disciplinary problems in school? ☐ Yes ☐ No

If yes, please describe: _____

How do you rate your child/adolescent's school experience on a scale of 1-5 where 1 is extremely negative and 5 is extremely positive?

1 2 3 4 5
Negative Average Positive

Legal History/Social Agency Involvements:

Has your child/adolescent been involved with the justice system? (e.g., arrest, detention, court, etc.) ☐Yes ☐No

If yes, please describe:_____

Has the child/adolescent ever had any involvement with the Department of Children & Families or a similar agency in Florida or another state? ☐ Yes ☐ No

PREVIOUS COUNSELING

List any previous counseling, psychiatric treatment, or residential/in-patient care the client has have received. (Use back if necessary)

Therapist: _____ Location: _____ Dates: _____ Reason: _____

Therapist: _____ Location: _____ Dates: _____ Reason: _____

MEDICAL INFORMATION

Primary Physician: _____ City: _____ Zip: _____

Is your child/adolescent currently receiving medical treatment? ☐ Yes ☐ No. If yes, please specify: _____

List significant conditions, illnesses, surgeries, hospitalizations, traumas, or treatments the client has had. (Use back if necessary.)

_____

_____

List all current medications the client is taking, including those that are seldom use or take only as needed. Also include and over-the-counter herbal medications(use back if necessary.)

Medication	Dosage	Purpose for Medication

Is the client taking these medication(s) according to the doctor's recommendations. ☐ Yes ☐ No

If no, briefly explain: _____

Has a physician ever recommended any anti-anxiety, anti-depressant, ADHD, or anti-psychotic medication for your child / adolescent? ☐ Yes ☐ No

If yes, please describe:_____

What diagnosis was your child / adolescent given?_____

Has anyone in your child/adolescent's family ever been treated or hospitalized for mental health issues, substance abuse, or psychiatric conditions? ☐ Yes ☐ No

If yes, please describe:_____

I, _____ (Parent/Legal Guardian), certify that the above information is true and complete. My signature below acknowledges that I have completed this information to the best of my knowledge and I have read and understand the conditions, statements, and authorizations disclosed.

_____ *Date:*_____

(Signature of Parent/Guardian)

CHILD / ADOLESCENT COMPLETES THIS SECTION
(TO BE COMPLETED AGE 12+)

What has led you to seek counseling at this time?_____

_____

_____

What specific goals do you hope to achieve during the counseling experience? _____

_____

_____

Please list your strengths:_____

_____

_____

FAMILY HISTORY:

How would you describe your relationship with your mother? ☐ Excellent ☐ Good ☐ Fair ☐ Poor

How would you describe your relationship with your father? ☐ Excellent ☐ Good ☐ Fair ☐ Poor

Do you have stepparents?

If yes, how would you describe your relationship with your stepparents? ☐ Excellent ☐ Good ☐ Fair ☐ Poor

Do you have siblings? ☐ Yes ☐ No

If yes, how would you describe your relationship with your siblings? ☐ Excellent ☐ Good ☐ Fair ☐ Poor

EDUCATION:

How would you rate your school experience on a scale of 1-5 where 1 is extremely negative and 5 is extremely positive?

_____

1 2 3 4 5
Negative Average Positive

SUBSTANCE ABUSE:

Which of the following have you tried or used?

☐ Wine
☐ Acid
☐ Cocaine
☐ Cigarettes
☐ Beer
☐ Speed
☐ Marijuana
☐ Liquor
☐ Downers
☐ Over the Counter Medicine
☐ Ecstasy
☐ LSD/Heroine
☐ Tobacco
☐ PCP
☐ Other:_____

At what age did you first use?_____ Have you ever used drugs before or during school? ☐ Yes ☐ No

Have you ever missed school or been truant because of substance abuse? ☐ Yes ☐ No

Do you ever feel pressure to use? ☐ Yes ☐ No

If you use alcohol or drugs, how often do you use them?

☐ Everyday ☐ Two or more times per week ☐ Weekends ☐ Other:_____
☐ Once a Year ☐ Holidays ☐ Once/Twice a month

ABUSE / TRAUMA HISTORY

Have you ever been abused? ☐ Yes ☐ No If yes, please describe:_____

Have you ever been sexually abused? ☐ Yes ☐ No If yes, please describe:_____

Have you ever been emotionally or mentally abused? ☐ Yes ☐ No If yes, please describe:_____

_____

Have you ever experienced any other severe trauma? ☐ Yes ☐ No If yes, please describe:_____

_____

CHILD / ADOLESCENT COMPLETES THIS SECTION:

RELIGIOUS / SPIRITUAL:

Are spiritual or religious issues important to you? ☐ Yes ☐ No

Do you wish to discuss them in counseling? ☐ Yes ☐ No

How would you rate your overall involvement in spiritual or religious activities on a scale from 1-5 where 1 is not involved and 5 is very involved?

1	2	3	4	5
Not Involved		Average		Very Involved

Currently, how would you rate your spiritual or religious experience on a scale of 1-5, where 1 is very harmful and 5 is very helpful?

1	2	3	4	5
Very Harmful		Average		Very Helpful

Please describe your relationship with God:_____

_____

LEVEL OF DISTRESS

Mental Status:

How would you describe yourself:_____

_____

Indicate how distressed you are by placing an"X" on the scale below (1= Very Little Distress; 10= Extreme Distress):

1	2	3	4	5	6	7	8	9	10

Are you currently experiencing any suicidal thoughts? ☐ Yes ☐ No. Have you experienced them in the past? ☐ Yes ☐ No

Have you ever attempted suicide? ☐ Yes ☐ No. I yes, when & how? _____

Have any of your friends or family ever committed or attempted suicide? ☐ Yes ☐ No. If yes, explain on back:

Who is part of your support system?_____

If you feel like hurting yourself, who would you tell?_____

☐ Happy ☐ Sad ☐ Depressed ☐ Lonely ☐ Hurt ☐ Angry ☐ Other:_____

Do you see or hear things others do not? ☐ Yes ☐ No Describe:_____

I, _____ (Client-Child/Adolescent), certify that the above information is true and complete and that I have completed this information to the best of my knowledge.

_____ _____

Signature of Client (Child/Adolescent) *Signature of Parent/Guardian*